

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (922)

CERTIFICATE OF DEATH

12060

Reg. Dist. No. 50

1. PLACE OF DEATH:

County CalvertCity or town Pusby
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Pusby
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Willistine Bishop

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Black

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Feb-1-1935

8. AGE:

Years

Months

Days

If less than one day

10102

.....hrs.min.

9. Birthplace

Pusby, Maryland
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

William J. Bishop

13. Birthplace

Maryland

MOTHER

14. Maiden name

Audrey Johnson

15. Birthplace

Maryland

16. Informant

William J. Bishop

Address

Pusby, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St. John

Location

Pusby, Maryland

18. Funeral director

P. Sewell

Address

Prince Frederick, Md

19.

(Date rec'd by registrar)

19

45A.E.S. Oster

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 - 1945 at 11A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1945 to December 3, 1945 and that I last saw her alive on Dec. 2 - 1945

Immediate cause of death

Chronic Valvular Heart Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Dr. E. S. Oster

M. D. or other

Address

Solomons, Md

Date signed

12/3/45

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DEC 8 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Adelphi
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Adelphi
(If outside city or town limits, write RURAL and give nearest town)Street No. -
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

Elas W. Bowen Jr.

3. (b) Social Security Number

No

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Fannie W. Bowen

7. Birth date of

deceased (mo., day, yr.)

March 16, 18556. (c) If alive, give age 78 years

8. AGE:

Years

90

Months

9

Days

13

If less than one day

.....hrs.min.

9. Birthplace

Calvert Co. MD.
(Town, county, and state)

10. Usual occupation

Farm + Woodwork

11. Industry or business

MOTHER FATHER

12. Name

Abram Bowen

13. Birthplace

Calvert Co. MD.

14. Maiden name

Fannie Simmons

15. Birthplace

Calvert Co. MD.

16. Informant

Perry G. Bowen Jr.

Address

Adelphi

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 31, 1945
(month) (day) (year)

Cemetery or crematory

Central

Location

Barnston

19. Funeral director

A. A. Harkness & Son

Address

Mutual, Md

19.

Dec 31, 1945
(Date rec'd by registrar)J. N. King
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1945 at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., 19....., at

and that I last saw him.....alive on.....19.....

Immediate cause of death

Generalized Anemia

DURATION

Due to

Intoxication

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Page J. St.
Anna Harkness

M. D. or other

Address: Date signed 12/31/45

1945

UNITED STATES DEPARTMENT OF JUSTICE

HEADQUARTERS

RECEIVED
JAN 7 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 86

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH

County Advert
City or town Crunk, Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Ch. is Hosp.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Caldwell
City or town Huntingtown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Daisy Winifred Brooks

3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, year) Nov. 26, 1945 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Caldwell Co. Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Nursery Brooks

13. Birthplace Cald. Co. Md.

14. Maiden name Daisy Mackay

15. Birthplace Cald. Co. Md.

16. Informant Nursery Brooks

Address Huntingtown Md

17. (Burial, cremation, or removal. Which?) _____ Date thereof _____ (month) (day) (year)

Cemetery or crematory _____

Location _____

18. Funeral director _____

Address _____

19. May 5 1946 N. W. Ward Registrar

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1945, at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 12/24 1945 and that I last saw him alive on 12/24 1945

Immediate cause of death Infantile Tetany

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Page 1st M. D. or other

Address Crunk, Frederick Date signed 12/25/45

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

This certificate was filed by J. Farnin

RECEIVED
MAY 8 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH

County CalvertCity or town Ches. Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Ches. Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Lucenie Brown

3. (b) Social Security Number

4. Sex

7

5. Color or race

C

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 18 1941

6. (c) If alive, give ago _____ years

8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

9. Birthplace

Ches. Beach

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Dec 18 45
(month) (day) (year)

Cemetery or crematory

Location

16. Funeral director

Address

19. Dec 17 19 45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 17 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16 1945 to Dec 17 1945and that I last saw her alive on Dec 16 1945

Immediate cause of death

Bronchial pneumonia

DURATION

1 wk

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Ches. Beach Date signed

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JAN 7 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12063 51

1. PLACE OF DEATH:

County MDCity or town Huntingtown MD
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Huntingtown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war No

3. (a) FULL NAME

Samuel C. Cox

3. (b) Social Security Number

No

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Adelle H. Cox6. (c) If alive, give age 71 years

7. Birth date of

deceased (mo., day, yr.)

January 30, 1873

8. AGE:

Years 72Months 10Days 8

If less than one day

.....hrs.min.

9. Birthplace

Huntingtown, Ind
(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

Farming

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 12/11

(Date rec'd by registrar)

19. 41

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 8 Dec 1945 at 845 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 Nov 1943 to 8 Dec 1945and that I last saw him alive on 8 Dec 1945

Immediate cause of death

Cerebral accident

Due to

Hypertension

Due to

atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Huntingtown MD M. D. or otherAddress Huntingtown MD Date signed 5 Dec 45

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DEC 12 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph Edelen

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Oct. 1855

8. AGE:

89

Years

Months

2

Days

If less than one day

hrs. min.

9. Birthplace

MD.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Susie Giles

15. Birthplace

MD

16. Informant

Ernest Hawkins

Address

Dunkirk, MD17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12-23-95
(month) (day) (year)

Cemetery or crematory

Halls Creek

Location

Dunkirk, MD.

18. Funeral director

P.E. Seirell

Address

Prince Frederick, MD19. 12-2319 4519 45

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

MD

County

Calvert

City or town

Dunkirk
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/2119 45at 6⁰⁰

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/1519 45to 12/2119 45and that I last saw him alive on 12/1919 45

Immediate cause of death

arteriosclerosis

DURATION

10 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. M. Ward

M. D. or other

Address Gray roadDate signed 12/21/45

RECEIVED
DEC 28 1945
BUREAU VER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 724

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
 City or town Island Creek
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Calvert
 City or town Island Creek
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah F. Gray

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced X

6.(b) Name of husband or wife Wm. J. Gray6.(c) If alive, give age 75 years7. Birth date of deceased (mo., day, yr.) Sept 22, 1876

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace md
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Charles Hook13. Birthplace mdMOTHER 14. Maiden name Sarah Taylor15. Birthplace md16. Informant William GrayAddress Island Creek md17. Burial, cremation, or removal. Which? Burial Date thereof 12-6-45
(month) (day) (year)Cemetery or crematory Brook's ChapelLocation Calvert18. Funeral director P.E. SewellAddress Prince Frederick md

19. 12-6 45 L. N. King
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12, 3, 1945 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1945 to Dec 3 1945
 and that I last saw him alive on Dec 3 1945

Immediate cause of death Acute coronary thrombosisDue to hypertension c.v. d

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Rd. Villanueva M. D. or other

Address Prince Frederick Md Date signed 12-6-45

FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

DATE: 12/8/45

TO: SAC, NEW YORK

RECORDED
DEC 8 1945
BUREAU V.S.

ADMINISTRATIVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County.....*Calvert Hospital*
 City or town.....*Prince Frederick md*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? *2 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*md* County.....*Calvert*
 City or town..... *Huntingtown md*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Fannie Jefferson

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F *C.* *X*

6.(b) Name of husband or wife.....

.....6.(c) If olive, give age..... years
 7. Birth date of deceased (mo., day, yr.) *June 22, 1876*

8. AGE: Years Months Days If less than one day
69hrs.min.

9. Birthplace.....*md*
 (Town, county, and state)

10. Usual occupation.....*Domestic*

11. Industry or business

12. Name.....*Patrick Ganitt*13. Birthplace.....*md*14. Maiden name.....*Lizzie Gray*15. Birthplace.....*md*16. Informant.....*Alton Jefferson*Address.....*Huntingtown md*

17. *Burial* (Burial, cremation, or removal. Which?) Date thereof.....*12-26-45*
 (month) (day) (year)

Cemetery or crematory.....*(Hunt) Protestant*Location.....*Calvert*18. Funeral director.....*P. E. Buell*Address.....*Prince Frederick md*

19. *May 5, 1946* (Date rec'd by registrar) Registrar.....*md*

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*12, 22, 1945* at.....*8P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19..... to.....*Dec 22* 19.....*45*
 and that I last saw him alive on.....*Dec 22* 19.....*45*

Immediate cause of death.....

*Uremia*Due to.....*hypertension c.v.d*Due to.....*hypertension*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address.....*Prince Frederick md* Date signed.....*Dec 26*
 M. D. or other

This certificate held by D. Farnis

UNITED STATES GOVERNMENT
DEPARTMENT OF JUSTICE
BUREAU OF PRISONS
WASHINGTON, D. C.

RECEIVED
MAY 8 1946
BUREAU OF PRISONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:

County CabaretCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County CabaretCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Sarah Jane Lore4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W6. (b) Name of husband or wife Joseph C. Lore Jr

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 7 18668. AGE: Years 79 Months 5 Days ? If less than one day _____ hrs. _____ min.9. Birthplace Cabaret Co., Ind
(Town, county, and state)10. Usual occupation Home

11. Industry or business

12. Name Samuel J. Tucker13. Birthplace Ind14. Maiden name Francis Keller15. Birthplace Ind16. Informant Joseph C. Lore Jr.Address Solomons, Ind17. Burial Date thereof Dec. 17, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Solomons M. E.Location Solomons, Ind18. Funeral director P. A. Harkness & SonAddress Mutual Ind19. 12/17/45 A. E. S. Coster
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

Lore

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 to Dec 5 1945and that I last saw him alive on _____ 19____Immediate cause of death Carcinoma of Rectum

DUE TO _____

DUE TO _____

DUE TO _____

DUE TO _____

DUE TO _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations Extensive carcinoma of rectum + sigmoidAutopsy results _____ Date of op. Sept 1945

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Whom did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George J. Harkness M. D. or other _____Address 12/15/45 Date signed _____

RECEIVED

DEC 22 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
 City or town Small Neck
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:
Calvert County Hosp.
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Calvert
 City or town North Beach
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Alma Max Williams

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Huber Max Williams
 7. Birth date of deceased (mo., day, yr.) September 25, 1888
 6. (c) If alive, give age _____ years
 8. AGE: Years 57 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace S. Carolina
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____
 12. Name Waldrop
 13. Birthplace _____
 14. Maiden name _____
 15. Birthplace _____

16. Informant _____
 Address _____
 17. Burial Date thereof 28 Dec 45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location Lee Funeral Home
300 4th N.E. Washington D.C.
 18. Funeral director L.B. King
 Address _____
 19. 12-28 19 45
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1945 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/14 19 45, to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____
 Immediate cause of death Heart Failure

Due to Coronary Occlusion
 Due to _____
 Other conditions Pulmonary Infarct
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Page Dist M. D. or other _____
 Address Small Neck Date signed 12/28

DEC 29 1945

Received
DEC 29 1945
Bureau Y.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Mutual Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CalvertCity or town Mutual
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary J. Parker

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

1855

8. AGE:

Years

Months

Days

If less than one day

90

.....hrs.min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business _____

FATHER

12. Name

Nelson Saunders

13. Birthplace

Md.

14. Maiden name

Elisabeth Eiggins

15. Birthplace

Md.

16. Informant

Joseph Saunders

Address

Mutual, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

12/14/45
(month) (day) (year)

Cemetery or crematory

Carels

Location

Calvert Co., Md.

18. Funeral director

P.E. Sewell

Address

Prince Frederick, Md.

19.

(Date rec'd by registrar)

19. 45L. N. King

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/45 19. 45 at 7:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 14 19. 45 to Dec 14 19. 45

and that I last saw him alive on 19.

Immediate cause of death

Heart failure

DURATION

Due to

hypertension arterio-sclerotic

Due to

vascular disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

R. de Villanueva

M. D. or other

Address

Prince FrederickDate signed 12/14/45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

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PLACE OF DEPARTURE

RECEIVED

DEC 19 1945

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 12060 51

1. PLACE OF DEATH:

County Prince Frederick

City or town Cabot
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Seaside at N. Beach

How long in hospital or institution? 3 day

3. (a) FULL NAME

Isidore M. Robey

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Beryl Robey

7. Birth date of deceased (mo., day, yr.) 1877, Aug. 8. (c) If alive, give age 65 years

8. AGE: Years 68 Months 4 Days — If less than one day
hrs. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Retired shoe factory

11. Industry or business Shoe factory

12. Name Isidore M. Robey

13. Birthplace Va.

14. Maiden name Sarah

15. Birthplace Va.

16. Informant Bennett E. Cheek

Address N. Beach Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12/10 (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Baltimore Md.

18. Funeral director W. H. Hatcher

Address Owings Md

19. 12/10 19 44 E. V. Kuie

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va County Calvert

City or town North Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2. (a) If veteran, name war —

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 10 19 45 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/8 19 45 to 12/10 19 45

and that I last saw him alive on 12/9 19 45

Immediate cause of death Cardiovascular

disease

Due to acute myocarditis

Due to —

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —

Antopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE H. W. Ward

Address Orinip Md Date signed 12/11/45

M. D. or other —

Address — Date signed —

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED
DEC 12 1945
BUREAU OF INVESTIGATION